

U.S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of CAROLYN J. HORN, claiming as widow of JERRY L. HORN and
DEPARTMENT OF THE AIR FORCE, TINKER AIR FORCE BASE, Okla.

Docket No. 96-1974; Submitted on the Record;
Issued October 2, 1998

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
BRADLEY T. KNOTT

The issue is whether the employee's death was causally related to his accepted employment injury, thereby entitling appellant to survivor benefits.

On July 11, 1975 the employee, then a 40-year-old production controller, filed a claim asserting that he developed a nervous disorder in the performance of duty. On August 8, 1975 Dr. Moorman P. Prosser, a Board-certified psychiatrist, reported that the employee was examined on July 30, 1975 and found to suffer a very severe anxiety neurosis predicated upon an obsessive compulsive personality basis. Dr. Prosser explained that the employee had always wanted to perform his duties adequately and well but found it impossible to do so during the last several months:

"Currently, and for some time, [the employee] has been assigned as scheduler in Production Control. On about August 1, 1974, he was assigned temporary responsibility as supervisory production controller in charge of a scheduling section, without benefit of official action either as a temporary promotion or official detail. He performed in this status beyond time limits established by regulations, being cognizant of the extreme work load placed on the organization due to work load and personnel transfer. There were no available personnel to relieve him of his ordinary duties, so he actually assumed the supervisory responsibility and three monitorships in addition to his regular job.

"In mid-December, nearing the calendar year end, and facing a Christmas shut-down from December 20, 1974 to January 2, 1975 deadlines and suspense dates for actions and/or reports became more critical, and he began to experience periods of nervous prostration and gastric disturbance. During the remainder of December he brought milk and cream soups to work for lunch and used antacid tablets daily. He tried to renounce the supervisory responsibility on two occasions, but was advised to 'hang on' and he would be assigned to the position.

“In January 1975 the pressure and short time schedules were equally as imposing as in December in an effort to catch up on work left incomplete during the Christmas closure. On January 16, 1975 following an intense work load conference, he had an extremely unpleasant encounter with one of his coworkers, and was then told he would not be permanently assigned to the supervisory position. Later in the day he suffered an acute muscle spasm in his left shoulder, requiring pain medication (Darvon 250 mg.) to withstand the pain. He became so distraught he could barely force himself to stay at work. By January 24, 1975 he was barely able to function mentally, and wrote a letter to his immediate supervisor requesting to be relieved of the responsibility of supervisory person and the monitorships he had assumed, in the belief that this action would in turn relieve the gastric disturbances, muscle spasm and anxiety.

“He was relieved of the supervisory responsibility but continued to be extremely nervous and had almost continuous shoulder pain. The gastric problems were less severe, but still present. The most noticeable symptom was an almost daily fear to face job responsibilities that had never bothered him. Urgent reports or suspense dates created near emotional panic, and he would perspire profusely in this type of situation. In addition, each morning as he prepares for work, the anticipation of pressure related events terrifies him to the point that he is reluctant to even show up for work.

“Treatment has been instituted in an effort to help him alleviate the tension phenomena that he currently suffers, and which appears to have been grossly aggravated and brought into symptomatic status by the events of January 1975.”

On September 19, 1975 Dr. Prosser reported that, while the employee had become increasingly tense over a period of several months because of the occupational stresses to which he had been subjected, the severity of his current symptoms were precipitated and undoubtedly predicated upon the occurrences of the specific events on January 16, 1975. On November 12, 1975 Dr. Prosser reported that these events resulted in the acute neurotic phenomena traumatically affecting his body function. He reported that the employee's condition had deteriorated dramatically due to added duties and responsibility imposed on him to oversee the work load of another employee put on extended sick leave two weeks earlier. Dr. Prosser advised that the employee was under additional occupational stress and that his anxiety was intensified to a degree that prohibited further exposure to stress. He recommended that the employee be removed immediately from his work situation for an indefinite period of time and be accorded benefits applicable to a job-related injury.

The Office of Workers' Compensation Programs asked its medical adviser to review Dr. Prosser's report and advise whether the employee's diagnosed emotional condition was caused, aggravated or precipitated by factors of his employment. On January 7, 1976 the Office medical adviser stated: “It is my medical opinion that the claimant's nervous disorder was aggravated by conditions of his Federal employment.”

On January 20, 1976 the Office accepted that the employee sustained an anxiety neurosis, severe, with obsessive-compulsive base, while in the performance of duty.¹ The employee took disability retirement effective November 14, 1975 and elected to receive workers' compensation benefits in lieu of a disability retirement pension. The Office paid compensation for temporary total disability on the periodic compensation rolls beginning June 24, 1976.

The employing establishment referred the employee to Dr. Harold G. Sleeper, a psychiatrist. In a report dated March 20, 1978, Dr. Sleeper stated that a clinical psychiatric evaluation of the employee was performed and a detailed history taken on March 6, 1978. He stated that he reviewed information sent to him, including several reports from Dr. Prosser. The employee, he stated, underwent psychometric testing on March 16, 1978, the overall pattern of which showed a paranoid condition very close to an overt schizophrenia in a personality characterized by obsessiveness, depression and hypochondria. Dr. Sleeper reported as follows:

"The origin of this illness is somewhat more difficult to trace, since there is considerable debate concerning the origin of this type of illness in any case. In attempting to reconstruct the development of this pattern, it would appear that he has been a very compulsive individual all of his life, and that he did become increasingly hyperirritable and unstable on the job, finally becoming paranoid and developing physical symptoms which prevented him from continuing in such a stressful situation.

"Based on my experience with this type of case, it is my opinion that he would have developed these symptoms under any work situation in which he found himself, as evidenced by the fact that at present he cannot even accept the restrictions of psychometric testing without becoming distressed. Because of the simple fact that he was working at [the employing establishment] when he became ill, he blames [the employing establishment] for the illness. Certainly pressure of any kind would have aggravated this condition once it began, but ordinary pressures would have been as troublesome in aggravating it as extraordinary pressures. The fact that the symptoms have not subsided since he left [the employing establishment] would suggest that they were not a direct result of the circumstances under which they first appeared to be disabling.

"In conclusion, it appears that on the basis of his present findings, [the employee] is indeed disabled from even simple tasks. It is my opinion that the stress in his work was coincidental rather than causative to the onset of his illness. It is also my opinion that treatment in this case is likely to be ineffective. He is completely convinced of his conclusions, and is unlikely to change any of them."

On January 25, 1979 the Office advised Dr. Prosser that the accepted condition as related to work stress was aggravation of preexisting anxiety neurosis, severe with obsessive-

¹ On its Form CA-800, FECA Nonfatal Summary, the Office appeared to approve the employee's claim initially for the condition of anxiety neurosis, severe, with an obsessive-compulsive base, and then, apparently at some later time, the notation "aggravation of preexisting" was written above this accepted condition.

compulsive base. "As [the employee] has not been exposed to work stress since November 15, 1975," the Office stated, "we would appreciate your considered medical opinion as to whether [his] current condition is related to his work experience, whether you consider the aggravation was of a temporary nature."

In a report dated March 8, 1979, Dr. Prosser, who addressed whether the employee also had a back condition related to his federal employment, stated as follows:

"The second question asked is whether I would consider the 'aggravation was of temporary nature.' I must answer this as No. I wish that it were temporary. I feel that both the emotional disorder and the residuals of the physical handicapping are ongoing disorders; indeed, since the surgery and even more since his last conference with Dr. Lisle in which he said that he knew of nothing more that could be done surgically to assist him at this time. His emotional state has been aggravated and he [is] much more apprehensive, introspective and depressed."

On April 10, 1979 the Office referred the employee, together with the medical record and a statement of accepted facts,² to Dr. Max A. Glaze, a specialist in neuropsychiatry, for an opinion on whether there was any etiologic contribution of the circumstances or conditions of the employee's federal employment and any psychiatric impairment. On May 1, 1979 Dr. Glaze reported that he saw the employee on April 25 and 30, 1979. He stated that he received and reviewed numerous reports from the employee's attending physicians, as well as statements from both the employee and the employing establishment. Dr. Glaze related in detail the employee's history, course of treatment and complaints. He diagnosed anxiety neurosis, severe with depression, and stated as follows:

"Although this man appears to have been a chronically obsessive, somewhat tense individual, he apparently did tolerate job and life pressures until placed under excessive demands at work which appears to have precipitated, aggravated and accelerated his anxiety depression.

"Apparently that aggravation was temporary and stopped when the patient received retirement; however, I do feel there is aggravation that sounds reasonably based in the sense that this man has apparently accepted the Department of Labor quite well and feels kindly towards them. He states when he was retired from [the employing establishment] he was supposedly separated from them and now becomes quite upset when any requests from [the employing establishment] are made for doctors reports or further information."

Dr. Glaze stated that he did not feel that the employee's difficulties or symptomatology were self-generated and that currently the employee remained quite seriously ill. "I feel this is chronic," he stated, "and the prognosis would appear poor."

² An undated statement of accepted facts, which appears from its placement in the record to have been drafted in early 1979, states that the employee suffered anxiety neurosis which he related to additional work load resulting from a temporary assignment as a supervisor in a personnel shortage.

On August 20, 1982 the Office referred the employee, together with the medical record and a statement of accepted facts, to Dr. Joseph B. Ruffin, a psychiatrist, for an opinion on any etiologic contribution of the circumstances or conditions of the employee's federal employment and any psychiatric impairment. In the statement of accepted facts, the Office advised Dr. Ruffin that it accepted as work related a temporary aggravation of a preexisting anxiety neurosis with an obsessive compulsive base. In a report dated March 18, 1983, Dr. Ruffin related the employee's history and his clinical observations. He stated that he really did not know what to call the employee's disorder:

"What he has done functionally is to just plain quit the world of work and in effect has both gone on strike and quarantined himself as his solution to the problem that developed some years ago. It is really amazing to me that this state of affairs would be seven years in obtaining its present state of resolution (or lack of resolution), and I am wondering what factors or elements keep it alive. I am plainly mystified by the whole process."

* * *

"[The employee] being a good compulsive cannot help but be hating himself for the radical solution of total unemployment that he has prescribed for himself. To this extent, the fact of his compulsive personality structure and his present 'remedy' must leave him in a state of intolerable conflict. This is all part of the sequence of employment factors as they interact with his fundamentals of his personality style."

* * *

"In response to your second question, there is no question that his present state of mind dictates (unless somebody else can develop evidence to successfully challenge [the employee's] position) that he is disabled for all work....

"I believe this is about as much as I can do with this consultation at this time. I might want to see him again in another six months to a year, at which point I might have some other ideas and be able to enlarge my perspective of this gentleman. If there are any other questions where you want me to dilate on some other aspects of the letter requesting consultation, please let me know, although I have chosen not to do so since in [the supervisory claims examiner's] note he indicated that the D.O.L. Office had accepted temporary aggravation of a preexisting anxiety neurosis with an obsessive-compulsive base. I [am] wondering about that phrase, 'preexisting anxiety neurosis with obsessive-compulsive base.' I did not realize that there was a 'preexisting anxiety neurosis' in this gentleman, and he mentions nothing to suggest this.

"Clearly he is a compulsive personality type who did get into a state of substantial emotional turmoil in connection with his occupational situation. (I can elicit no information related to extra-occupational factors.) As indicated above, on the basis of data available to me, I am concluding that what we are observing in this

gentleman is the leveling out of a wave of emotional upset now going into the eleventh year (!!!) of its subsidence, most probably perpetuated by the secondary gain (compensation status)."

In a supplemental report dated April 26, 1983, Dr. Ruffin stated:

"Regarding the question as to whether or not [the employee's] present condition is related to the specific factors mentioned in the Statement of Accepted Facts, I feel confident that his *present* emotional state is surely not a direct product of those circumstances of the specific incident(s) alluded to in the statement. (Emphasis in the original.)

"The present and continuing emotional state is directly related to his compulsive personality structure in several respects: First, there is the continuing anger he has toward himself for being, in fact, unemployed, 'unimportant,' and not gainfully occupied. Second, to protect his own fragmented sense of worth, his mind constructs and maintains a mental posture which justifies, however, feebly, the continuing state of affairs and this is accomplished through a variety of intellectualizations mentioned in the report -- the matter of his refusal-incapability to deal with any type of demand situation, the continuing focus on 'having been cheated,' the program of perpetual indignation, etc., etc., etc. All of this results in the continuing arousal of distressing emotion.

"This inability to cope with any type of work situation is directly related to a specific mental set, which allow no room for compromise of the position which he has taken, namely that he will never subject himself to any form of demand situation again. This is not simply the outcome of his compulsive personality structure, but is the end stage of his thinking which he has no choice but to maintain, however, unfavorable the consequences are to himself."

Dr. Ruffin stated that the employee was a person of considerable integrity and scrupulosity, and that he did not think that the employee was malingering. He summarized his opinion as follows:

"This gentleman is now trapped within his own prescription for his problem. His radical solution to the problem of managing limits and other dimensions in the employment situation has led to a sickness from which he cannot let himself recover. The sickness state is maintained by a set of thinking patterns which are rooted in this compulsive personality structure and also by the motive to preserve his financial basis."

An Office medical adviser reported on June 10, 1983 that the employee had been assigned temporary responsibilities as a supervisor/production controller in August 1974, which job was recognized as beyond his ability to cope, and early in 1975 he became extremely nervous, experiencing muscle spasms, gastric disturbances and an overwhelming fear of returning to the job. The medical advisor noted that the employee's diagnosis in 1975 was anxiety neurosis, severe, with an underlying, predisposing obsessive-compulsive personality

disorder. "In other words," he stated, "[the employee] was an extremely conscientious man who could not meet the demands of his own conscience, and as a result became increasingly anxious and fearful." The medical adviser continued as follows:

"When a very meticulous, highly self-critical person is subjected to demands to which he cannot live up [to], he may experience different kinds of symptoms, including depression, blaming the job, or emotionally based physical symptoms. In this case, [the employee] has utilized all three mechanisms. He experiences muscle spasms, blames his former employers, and feels badly about himself."

* * *

"There is no evidence that [the employee] has improved over the years. I have to take issue with Dr. Ruffin's report[s].... He correctly points to [the employee's] uncompromising nature and to some of the factors involved in his psychological development, but Dr. Ruffin loses sight of the fact that the stress of being unable to live up to his own standards has permanently impaired [the employee's] judgment and emotional control, and that he truly lacks the capacity for returning to work. [The employee] is not sulking, he continues to be totally disabled by a severe emotional disorder."

Dr. Prosser continued to submit periodic progress reports of his treatment of the employee's anxiety neurosis with an obsessive-compulsive base. On October 22, 1986 he noted that the employee had heart bypass surgery in November 1985, at which time five arteries were replaced with three of these currently occluded. Dr. Prosser stated that the employee's anxiety neurosis was still quite impairing in itself and was aggravated by his cardiac problems.

In an April 18, 1988 report to Dr. Prosser, Dr. Yee Se C. Ong, a Board-certified specialist in cardiovascular diseases, stated as follows:

"[The employee] has been treated by this office since December 1985, as a post-surgical management patient, after he underwent a quintuple coronary artery bypass graft. In June 1986, two by-pass grafts totally occluded, and he suffered a myocardial infarction with each occlusion, and sustained moderate ventricular impairment."

In a May 20, 1988 report to Dr. Ong, Dr. Prosser stated: "I must agree with you that continued anxiety and tension certainly serve as a threat to his cardiac stability and survival. He finds that if he quits smoking his anxiety increases."

On November 14, 1988 Dr. Prosser reported that the employee had been seen with regularity in supportive and directive medical psychotherapy for his neurotic depression and obsessive compulsive disorder, formerly called anxiety neurosis. He noted improvement but stated that his psychiatric diagnosis in this case had not changed.

The Office received an October 31, 1989 report from Dr. Joe G. Savage, a psychologist and associate of Dr. Prosser. Dr. Savage advised that Dr. Prosser had died in February 1989. He reported the following:

“On August 22, 1989 I engaged [the employee] in a session of hypnotherapy, in an attempt to help him with his chronic smoking. He has been advised that he needs to quit smoking because of his cardiac status and the condition of his arteries. However, every time he tries to stop smoking it aggravates his anxiety state, which only causes him to want to smoke more. He does smoke to tranquilize himself and is unable to stop it, even with the aid of hypnotherapy suggestion. It would be highly advisable that this man stop smoking, considering the many problems he has involving his vascular system, but because of his emotional problems, specifically the anxiety and depression and tension phenomenon, with his obsessive compulsive personality problems, he has not been able to do so.”

On February 3, 1992 Dr. Savage reported that the employee had recently had an exacerbation of his chest pain and had experienced one of his worst spells of angina. Noting that these factors were contributing to the employee’s anxiety, Dr. Savage stated as follows:

“The causal relationship of this man’s diagnosis for which he is on Workman’s Compensation and the factors of employment have been previously outlined in earlier reports and are a matter of record. The patient continues to be 100 percent totally disabled for engaging in any gainful employment and if he were to go back to regular employment, he would very rapidly get worse and his condition would become very unstable. His condition is continuous, at best at this point, and we hope that some intervention into his cardiac problem may help stabilize him a little better. I feel very certain, however, that if he did not have the stresses and anxiety disorder that he developed while employed for the government, that he would be handling these other problems much better and might not even have them.”

On December 7, 1993 Dr. Savage reported that the condition the employee was currently suffering was the same condition he suffered since he first developed the disability while he was employed by the federal government. The condition was fairly static at this point, he stated, with not much improvement observed. He added: “I am sure that the anxiety that he has from time to time causes some chest pain.”

The employee died on August 19, 1994. His death certificate listed the causes of death as ventricular cardiac arrhythmia, advanced coronary artery disease and acute myocardial infarction. Appellant, the employee’s widow, filed for survivor benefits.

On November 3, 1994 Dr. Savage, at appellant’s request, submitted to the Office a report “to show that the heart disease was at least aggravated by [the employee’s] accepted condition of anxiety neurosis, and that it may have played an even more significant role in the development of his hear disease.” Dr. Savage related the employee’s history and reported as follows:

“[The employee] was put on medication, cardiac rehabilitation therapy, diet modification and underwent hypnosis in an effort to quit cigarette smoking. Although his efforts were sincere, each time he began to make significant progress, he seemed to undergo an episode of increased anxiety, and reverted back to smoking. Anxiety is recognized as a significant risk factor in cardiac management, and coupled with cigarette smoking, greatly accelerates the possibility of a severe, potentially fatal myocardial infarction. He seemed unable to stop smoking because of his anxiety neurosis and worsening of symptoms when he tried.

“I believe that [the employee’s] anxiety periodically caused him to have angina. He was told by his cardiologist that anxiety can cause a worsening of his cardiac condition. Anxiety raises cholesterol levels in the blood. It is generally accepted today that high cholesterol levels aggravate and probably cause arteriosclerotic disease. The American Heart Association advises reduction of cholesterol levels for this reason.

“It is my opinion that the stresses, and anxiety disorder that he developed while employed for [the employing establishment], and due to factors of employment, materially aggravated and probably caused his onset of angina, which was reported by [the employee] as indigestion in January 1975. He had never experienced chest pain prior to the documented and established stressors of his federal employment; which resulted in him being placed on compensation.

“His outcome, that of his cardiac disease, was directly the result of stress factors accepted as arising from factors of federal employment at [the employing establishment].”

The Office also received a December 6, 1994 report from Dr. A.S. Dahr, a specialist in cardiovascular diseases. Noting that he had taken care of the employee from April 1991 until he passed away in 1994, Dr. Dahr reported as follows:

“[The employee] had very advanced coronary artery disease. I managed him medically because there was no indication for redo surgery. He had had aortic coronary saphenous bypass surgery in 1985. He also had demonstrable peripheral vascular disease and demonstrable occlusive vascular disease in the neck and in the lower extremities as well.

“On reviewing Dr. Joe Savage’s letter dated November 3, 1994 in which he suggests that [the employee’s] stresses and anxieties aggravated his diffuse atherosclerosis is a very acceptable statement. Even though his diffuse atherosclerosis might not be entirely caused by stress and anxiety, it is conceivable that the stress and anxiety contributed at least and aggravated his sclerosis.”

The Office referred the employee’s death certificate, Dr. Savage’s November 3, 1994 report and Dr. Dahr’s December 6, 1994 report to an Office medical adviser for review and an

opinion on whether the employee's death was related to the accepted work-related condition, which he identified as "temporary aggravation of a preexisting anxiety neurosis with obsessive compulsive base." On April 6, 1995 the medical adviser reported as follows:

"It is very difficult to relate the claimant's demise to his job of nineteen years previously. The accepted condition of aggravation of an anxiety neurosis was temporary, and any aggravation would have ceased within a reasonable period of time after cessation of work. In my opinion, the job did not cause the neurosis, and job aggravation could only occur during the time of employment. Any continuation of anxiety after ceasing work, would be a result of the claimant's underlying disorder (anxiety neurosis), rather than the job. This claimant died of heart disease nineteen years after stopping work. Heart disease was not documented until 1986 -- eleven years after he ceased working. In my opinion, the job did not cause, or aggravate the cause, of his demise."

In a decision dated May 5, 1995, the Office denied appellant's claim for survivor benefits on the grounds that the Office medical adviser had found the cause of death not to be related to the employee's federal employment.

Appellant requested reconsideration and submitted additional medical evidence. In a report dated June 27, 1995, Dr. Savage took issue with the statement made by the Office medical adviser that the accepted condition of aggravation of an anxiety neurosis was temporary and that any aggravation would have ceased within a reasonable period of time after cessation of work. After quoting from Dr. Prosser's March 8, 1979 report, wherein Dr. Prosser advised the Office that the accepted condition of aggravation of preexisting anxiety neurosis, severe with obsessive-compulsive base, was not temporary, Dr. Savage reported as follows:

"I do not know what authority that the medical reviewer made the statement that the anxiety neurosis was temporary. It is only an assumption that any aggravation would have ceased within a reasonable period of time after cessation of work. I believe a thorough review of this patient's yearly reports will confirm the contrary. He did not improve to the point of being free of the anxiety neurosis which had been aggravated by factors of employment. One of the reasons is that one of the things that aggravated his anxiety neurosis was the chronic back pain that he suffered as a result of the back injury that he sustained while he was employed at [the employing establishment] which resulted in the chronic pain syndrome and aggravated his anxiety neurosis."

Dr. Savage quoted medical reports by Drs. Ong, Prosser and Dahr to support a causal relationship between anxiety and myocardial infarction, and stated as follows:

"I want to reiterate that the medical literature is full of references to the relationship of anxiety and stress to the worsening of cardiac conditions and also, to the raising of triglyceride levels and cholesterol levels. Both factors are accepted by all cardiologists as contributing to atherosclerotic disease. Certainly smoking aggravates this also, but one of the reasons [the employee] was unable to

stop smoking was because of his anxiety neurosis which continued to exist after its aggravation while he was working at [the employing establishment].”

In a decision dated October 18, 1995, the Office denied modification of its prior decision. The Office found that neither Dr. Dahr nor Dr. Savage had provided a rationalized opinion on how the employee’s work-related condition resulted in his death from heart disease that developed years after he stopped work. To correct the deficiencies in her case, the Office advised that appellant provide at a minimum: (1) a detailed statement regarding the circumstances leading up to the employee’s death, including his activities 24 hours prior to the onset of infarction; (2) copies of clinical records for all treatment provided by Dr. Dahr; (3) copies of all hospital records, if any, during the period immediately prior to death; and (4) a detailed report from the employee’s cardiologist that provides a rationalized opinion, with medical reasons, on how the employee’s psychiatric condition caused or materially hastened his death.

Appellant again requested information and submitted a statement of circumstances leading up to the employee’s death, Dr. Dahr’s discharge summary, copies of hospital records immediately prior to the employee’s death, and reports from both of the employee’s cardiologists.

In a report dated January 22, 1996, Dr. Ong stated that he had treated the employee from December 1985 to November 1991, during which time the employee had severe anxiety reaction and, as a result of this problem, was unable to stop smoking. Dr. Ong enclosed a copy of his April 18, 1988 letter to Dr. Prosser, which he stated explained his opinion that the employee’s anxiety condition played a significant role in his cardiovascular disease.

In a report dated November 17, 1995, Dr. Dahr stated as follows:

“I had now the privilege of reviewing more of [the employee’s] medical records relative to his long-standing anxiety neurosis. It seems that his anxiety contributed to his inability to quit cigarette-smoking as well. It is very acceptable that anxiety contributes to and aggravates coronary artery disease. It is acceptable that cigarette-smoking is a major detrimental risk factor for the development of diffuse atherosclerosis. With that in mind, namely that his life-long neurosis contributed to his inability to stop cigarette-smoking one can rationalize the conclusion that his anxiety neurosis contributed to his cigarette-smoking which definitely aggravated his coronary artery disease and peripheral vascular disease. His advanced coronary artery disease is the cause of his death at a relatively young age. I [am] in agreement with Dr. Savage’s letter of June 27, 1995 relating to the [employee]. I support the appeal and hope that you will look at it more favorably.”

In a decision dated March 22, 1996, the Office again denied modification of its prior decision. The Office discounted much of the evidence it had asked appellant to submit because the evidence provided no opinion on the relationship between the employee’s death and his anxiety neurosis. The Office found that Dr. Ong’s January 22, 1996 report did not provide a rationalized explanation of how the employee’s death on August 19, 1994 was causally related to

his anxiety neurosis or his employment, which ceased in November 1975. The Office also found that Dr. Dahr's November 17, 1995 opinion was generalized and speculative.

The Board finds that this case is not in posture for a determination of whether the employee's death was causally related to his accepted employment injury.

Appellant has the burden of establishing by the weight of the reliable, probative and substantial medical evidence that the employee's death was causally related to an employment injury or to factors of his federal employment. As part of this burden, appellant must submit a rationalized medical opinion, based upon a complete and accurate factual and medical background, showing a causal relationship between the employee's death and an employment injury or factors of his federal employment.³

Although some confusion arose over the years concerning the precise nature of the injury that the employee sustained while in the performance of duty, the early reports of Dr. Prosser, the employee's attending psychiatrist, make clear that the employee suffered a very severe anxiety neurosis, one that was predicated upon an obsessive-compulsive personality basis. It is important to note that the preexisting condition in this case is the obsessive-compulsive personality, not the anxiety neurosis. As Dr. Glaze, an Office referral psychiatrist, explained, the employee appeared to have been a chronically obsessive, somewhat tense individual but apparently did tolerate job and life pressures until placed under excessive demands at work. When the Office later advised Dr. Ruffin, another Office referral psychiatrist, that it had accepted the employee's claim for a temporary aggravation of a pre-existing anxiety neurosis with an obsessive-compulsive base, Dr. Ruffin remarked: "I [am] wondering about that phrase, 'preexisting anxiety neurosis with obsessive-compulsive base.' I did not realize that there was a 'preexisting anxiety neurosis' in this gentleman, and he mentions nothing to suggest this." Indeed, a careful review of the record discloses no medical evidence substantiating a preexisting anxiety neurosis. This tension phenomenon, as Dr. Prosser described it, began to develop in August 1974, when the employee assumed supervisory responsibilities and three monitorships in addition to his regular duties. Over the next several months the employee became increasingly tense such that specific events occurring in mid January 1975 precipitated "acute traumatic neurotic phenomena traumatically affecting his body function."

The question, therefore, for purposes of determining appellant's entitlement to survivor benefits, is whether the employee's death was causally related to the accepted anxiety neurosis.

The first medical evidence of causal relationship actually appears prior to the employee's death. On April 18, 1988 Dr. Ong, appellant's attending specialist in cardiovascular diseases, wrote to Dr. Prosser to solicit his assistance to increase the emphasis on modifying the employee's anxiety level and precluding the resumption of his smoking. Dr. Ong noted that two of the employee's five bypass grafts has occluded, causing myocardial infarctions and a moderate ventricular impairment. He explained that quitting cigarette smoking was recommended to reduce risk factors, but that each time the employee began to make significant

³ See *Leonora A. Bucco (Guido Bucco)*, 36 ECAB 588 (1985); *Lorraine E. Lambert (Arthur R. Lambert)*, 33 ECAB 1111 (1982).

progress, he seemed to undergo an episode of increased anxiety and revert back to smoking. Dr. Ong explained that anxiety was recognized as a significant risk factor in cardiac management and, coupled with cigarette smoking, greatly accelerated the possibility of a severe, potentially fatal myocardial infarction. He stated that the employee was certainly diminishing his survival expectancy with his “anxiety-related lifestyle management failures.”

Thus, more than six years before the employee died of a heart attack, his attending cardiologist was explaining how anxiety was a significant risk factor and could accelerate the possibility of a severe, potentially fatal myocardial infarction, particularly when coupled with cigarette smoking. Dr. Prosser, the attending psychiatrist, replied that he agreed that continued anxiety and tension certainly served as a threat to the employee’s cardiac stability and survival, and that his anxiety increased when he stopped smoking. These reports lay the foundation for appellant’s claim by supplying the medical basis for the element of causal relationship.

To support her claim for survivor benefits, appellant submitted additional reports from Dr. Savage and Dr. Dahr. In his November 3, 1994 report, Dr. Savage related the same medical reasoning put forth by Dr. Ong, that anxiety was recognized as a significant risk factor in cardiac management and, coupled with cigarette smoking, greatly accelerated the possibility of a severe, potentially fatal myocardial infarction, and that the employee seemed unable to stop smoking because of his anxiety neurosis and the worsening of symptoms when he tried. Dr. Savage also explained that anxiety raises cholesterol levels in the blood, and that it was generally accepted that high cholesterol levels aggravate and probably cause arteriosclerotic disease, which is the reason the American Heart Association advised reduction of cholesterol levels. Noting that the employee had never experienced chest pain prior to the accepted stressors in his federal employment, Dr. Savage offered his opinion that the stresses and anxiety disorder that the employee developed in his federal employment materially aggravated and probably cause the onset of his angina, and that his cardiac disease was directly the result of the stress factors accepted as arising from factors of his federal employment.

Dr. Dahr, appellant’s attending specialist in cardiovascular diseases, reviewed Dr. Savage’s report and advised that his was a very acceptable opinion. He supported that it was in fact conceivable that the employee’s stress and anxiety contributed, at least, and aggravated his diffuse atherosclerosis.

In a report dated June 27, 1995, Dr. Savage took issue with the statement made by the Office medical adviser that the accepted condition of aggravation of an anxiety neurosis was temporary and that any aggravation would have ceased within a reasonable period of time after cessation of work. He reiterated that the medical literature was full of references to the relationship of anxiety and stress to the worsening of cardiac conditions and also to the raising of triglyceride levels and cholesterol levels, both of which are accepted by all cardiologists as contributing to atherosclerotic disease. He stated that smoking certainly aggravated the employee’s atherosclerosis as well, and that the employee was unable to stop smoking was because of his anxiety neurosis.

Reports by Dr. Ong and Dr. Dahr then focused on how the employee’s anxiety neurosis contributed to his cigarette smoking, which in turn definitely aggravated his coronary artery disease and peripheral vascular disease. Noting that the employee’s advanced coronary artery

disease was the cause of his death at a relatively young age, Dr. Dahr expressed his agreement with Dr. Savage's letter of June 27, 1995.

Although this medical opinion evidence is reasoned and based on an accurate factual and medical background, the Board finds that it is insufficient to discharge appellant's burden of proof. Lacking in these reports is a clear explanation of how a causal relationship between the employee's death and his exposure to stress factors in his federal employment could have spanned such a lengthy period of time, over 19 years. This is not to suggest that the accepted exposure could not have contributed to the employee's death, only that when a physician attempts to bridge two such distant events, great care must be taken to make the connection clear, at least to a reasonable degree of medical certainty, so that the question of time no longer separates the two.⁴

The Board further finds that the opinion of the Office medical adviser, who found it very difficult to relate the employee's demise to his job 19 years earlier, is of little probative value and is insufficient to create a conflict in medical opinion.⁵ He based his opinion on an inaccurate factual background. The Office advised that the accepted condition was only a temporary aggravation, and the medical adviser assumed this to be the case. He reported that any continuation of anxiety after ceasing work would have been the result of the employee's underlying anxiety neurosis. As the Board has noted, however, the evidence in this case

⁴ Compare *Linda L. Mendenhall*, 41 ECAB 532 (1990), wherein the Board observed that when a physician delays diagnostic testing, uncertainty mounts and a question arises as to whether that testing in fact documents the injury claimed by the employee, and that when the delay becomes so significant that it calls into question the validity of an affirmative opinion based at least in part on that testing, such a delay diminishes the probative value of the opinion offered.

⁵ See 5 U.S.C. § 8123(a) "(if there disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary [Office] shall appoint a third physician who shall make an examination)."

indicates that the employee did not have a preexisting anxiety neurosis.⁶ The opinion of the medical adviser is also of little probative value because it lacks sound medical reasoning. The medical adviser stated that any aggravation would have ceased within a reasonable time after cessation of employment, but he failed to explain why the stressors in the employee's federal employment could not have had the lasting impact consistently reported by the attending physicians.⁷

Although the supporting medical opinion evidence is insufficient to discharge appellant's burden of proof, the Board finds that it is sufficiently supportive of appellant's claim that further development of the evidence is warranted.⁸ The Board will set aside the Office's March 22, 1996 decision and remand the case for a supplemental opinion explaining the 19-year span of the causal relationship posited by Drs. Ong, Savage and Dahr. After such further development as may be necessary, the Office shall issue an appropriate final decision on appellant's entitlement to survivor benefits.

The March 22, 1996 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action consistent with this opinion.

Dated, Washington, D.C.
October 2, 1998

Michael J. Walsh
Chairman

David S. Gerson
Member

Bradley T. Knott
Alternate Member

⁶ See *James A. Wyrick*, 31 ECAB 1805 (1980) (physician's report was entitled to little probative value because the history was both inaccurate and incomplete); see generally *Melvina Jackson*, 38 ECAB 443, 450 (1987) (addressing factors that bear on the probative value of medical opinions).

⁷ Medical conclusions unsupported by rationale are also of little probative value. *Ceferino L. Gonzales*, 32 ECAB 1591 (1981); *George Randolph Taylor*, 6 ECAB 968 (1954).

⁸ See *John J. Carlone*, 41 ECAB 345, 358 (1989) (finding that the medical evidence was not sufficient to discharge appellant's burden of proof but remanding the case for further development of the medical evidence given the uncontroverted inference of causal relationship raised).